IMPORTANT NOTICE
SPOUSAL PREMIUM SURCHARGE FORM

If this form is not received by the Human Resources Department/Benefits Division at each enrollment period and your spouse is enrolled in medical coverage, you will be charged the premium surcharge until the form is received. Any premiums that are deducted due to failure of turning in this form will not be refunded.

A $40.00 monthly surcharge will be added to your premium if you have elected to cover your spouse in a County sponsored medical plan and your spouse is eligible for coverage through his/her employer, but elects not to enroll. ***If your spouse is eligible for coverage as an employee or retiree of Clayton County Board of Commissioners, the spousal premium surcharge will be waived.***

☐ **My spouse is an active employee or a retiree of Clayton County Board of Commissioners**

Spouse name: _____

☐ **No coverage elected for spouse in County sponsored medical plan**

☐ **I have my spouse enrolled in County sponsored medical plan. My spouse does not work or is self employed**

☐ **I have my spouse enrolled in a County sponsored medical plan. My spouse does not have medical coverage available through his/her employer** ***(complete spouse employer/medical info below)***

☐ **I have my spouse enrolled in a County sponsored medical plan. My spouse is also enrolled in medical coverage through his/her employer** ***(complete spouse employer/medical info below)***

Spouse Employer/Medical Plan Information

Spouse Name: _____

Spouse Employer Name: _____

Employer Telephone Number: ( ) _____ Group # _____

Group Medical Plan Name: _____ Cert #: _____

Group Medical Plan Effective Date: _____

☐ **I have my spouse enrolled in County sponsored medical plan. My spouse has medical coverage available through his/her employer and has elected not to enroll in their medical coverage** ***(the $40 monthly surcharge will be applied)***

If your spouse loses or obtains medical coverage through his/her employer, you have one month from the effective date of your spouse's change in coverage to notify the Human Resources Department/Benefits Division. Failure to notify the Human Resources Department/Benefits Division in writing within one month of the date the medical coverage change occurred will prohibit you from making a change until the next Annual Open Enrollment period.

By signature below I confirm that all information provided on this form is true and correct to the best of my knowledge. Any false statements on this form or on future forms as it relates to spousal health information shall be considered as grounds for disciplinary action up to and including termination of employment.

I understand the $40.00 monthly premium surcharge will be applied to my medical deductions if applicable, and I authorize the additional premium to be deducted from my paycheck on a "pre-tax" basis. Premium surcharges deducted from pension checks will be deducted on an "after-tax" basis.

_____ _____ _____

Print Name Signature Date

Employee # _____ **Employment Status:** ☐ **Active** ☐ **Retiree**